Arizona Health Care Cost Containment System
Reinsurance Processing Manual

Effective 10/01/2008

REINSURANCE PROCESSING MANUAL
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Chapter One
General Information

I. Introduction

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's health care program for the indigent and medically needy, provides Reinsurance as a stop-loss program for Contractors to provide partial reimbursement beyond an annual deductible level for covered medical services for members with an acute medical condition. The *Reinsurance Processing Manual* contains information on the following topics:

- Acute Care Reinsurance
- ALTCS Reinsurance
- Catastrophic Reinsurance
- Transplants

Use of this manual, in conjunction with the AHCCCS Medical Policy Manual, will provide information regarding covered services, billing procedures and reimbursement policies related to reinsurance cases.

Please reference the AHCCCS Website at http://www.azahcccs.gov for a copy of this manual.

II. Contact Information

AHCCCS Reinsurance Finance	602-417-4539 602-417-4658 602-417-4156	Fax 602-417-4725
AHCCCS Medical Management	602-417-4556 602-417-4122 602-417-4579	Fax 602-417-4276
ALTCS Case Management	602-417-4359	

III. Definitions/Acronyms

ADHS	Arizona Department of Health Services
AHCCCS	Arizona Health Care Cost Containment System
ALO	Allogenic Related Bone Marrow Transplant
ALTCS	Arizona Long Term Care System
ALU	Allogenic Unrelated Bone Marrow Transplant
AUT	Autologous Bone Marrow Transplant
BCC	Breast and Cervical Cancer
BIO	Biotech Drug Coverage: The drugs covered are Cerazyme, Aldurazyme, Fabryzyme, Myozyme, and Elaprase. Ceprotin was added effective 10/01/2008. Kuvan and Orfadin are only covered under CRS and are not covered under Acute or ALTCS.
BEH	Behavioral Health
CASE	A record comprised of one or more adjudicated encounter(s)
CHM	Catastrophic Hemophilia
CLEAN CLAIM/ CLEAN STATUS/ CLEAN ENCOUNTER	A claim/encounter that may be processed without obtaining additional information from the provider or contractor of service or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, and has passed all of the Encounter and Reinsurance edits.
CKY	Cadaveric Kidney Transplant
COA	Council on Accreditation
Coinsurance	The percentage rate at which AHCCCS will reimburse the Contractor for covered services above the deductible
Contractor	Health Plan or Program Contractor
CRA	Catastrophic Regular Acute Reinsurance over $650,000

DES	Catastrophic DES-DDD
DHCM	Division of Health Care Management
DLL	Double Lung Transplant
DOS	Date of Service
Encounter	A record of a medically related service(s) rendered by a registered AHCCCS provider to an AHCCCS member enrolled with a capitated Contractor on the date of service
ECF	Extended Care Facility
ETW	Expanded Title XIX Waiver Group
GCC	Gaucher's Disease; an inherited metabolic disorder in which harmful quantities of a fatty substance called glucocerebroside accumulate in the spleen, liver, bone marrow and, in rare cases, the brain.
HEM	Hemophilia; The oldest known hereditary bleeding disorder. There are two types of hemophilia, A and B. The severity of hemophilia is related to the amount of clotting factor in the blood.
HLT	Heart Lung Transplant
HRT	Heart Transplant
IMD	Institution for Mental Disease
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KID	KidsCare
KDY	Kidney Transplant
KTP	KidsCare HIFA Parent
LIV	Liver Transplant
LMO	Long Term Care, Metro, Without Medicare
LMW	Long Term Care, Metro, With Medicare
LTC	Long Term Care
LRO	Long Term Care, Rural, Without Medicare

LRW	Long Term Care, Rural, With Medicare
LVN	Long Term Care von Willebrand's Disease
PAK	Pancreas after Kidney Transplant
PKY	Pediatric Kidney Transplant
PLV	Pediatric Liver Transplant
PPC	Prior Period Coverage: The period of time between the eligibility effective date and the date of enrollment with a contractor.
Prospective	The period of time from when the contractor receives notification the member has been assigned to their plan and they are prospectively capitated for the member.
PT	Provider Type
PTI	Post Transplant Inpatient Day 61-100
RAC	Regular Acute Care
RBHA	Regional Behavioral Health Authorities
Receiving	The Health Plan in which the member will become enrolled as a result of an Annual Enrollment Choice, open enrollment, or plan change choice.
Relinquishing	The Health Plan the member will be leaving as a result of a Health Plan Annual Enrollment Choice, open enrollment or plan change choice.
RI	Reinsurance
RTC	Residential Treatment Center
SLT	Single Lung Transplant
SNF	Skilled Nursing Facility: Nursing facility for those members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician.
SOT	State Only Termination reference the AHCCCS Medical Policy Manual, Chapter 400, Policy 410 “Maternity Care Services”.
SPK	Simultaneous Pancreas/Kidney Transplant
SSDI-TMC	Social Security Disability Insurance – Temporary Medical Coverage

SSI	Supplemental Security Income
ST1	State Only Transplant Option 1
TANF	Temporary Assistance to Needy Families
Title XIX Member	Member eligible for federally funded Medicaid programs under Title XIX of the Social Security Act.
Title XXI Member	Member eligible for acute care services under Title XXI of the Social Security Act.
TPL	Third Party Liability
VON	von Willebrand's Disease; An inherited blood disorder characterized by prolonged bleeding time. It is the most common hereditary bleeding disorder in humans.

Chapter Two
Regular Acute Reinsurance

I. Eligibility

Regular Acute Reinsurance (RAC case type) is provided to partially reimburse the Contractor for covered inpatient facility services as described in contract and this manual, when the cost of care for a member exceeds a deductible amount. All members who are prospectively enrolled with a Contractor on a capitated basis and meet the appropriate deductible amount are eligible for Reinsurance benefits, excluding SOBRA Family Planning, SSDI-TMC, State Only Transplants and PPC members. The deductible amounts and coinsurance percentages are detailed in contract. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered inpatient facility services incurred above the deductible.

II. Determination of Benefits

Services that are covered under Reinsurance are specified in the AHCCCS Reinsurance System on the RI325 screen titled "RI Covered Services".

In addition to inpatient facility services, per diem rates paid for nursing facility services provided within thirty (30) days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to ninety (90) days in any contract year shall be eligible for Reinsurance coverage. PPC inpatient expenses are not covered under the reinsurance program for any members unless they qualify under catastrophic or transplant reinsurance.

AHCCCS will utilize adjudicated encounters for services provided to determine Reinsurance benefits. Effective with dates of service 10/01/08 and after, the following services are covered:

- Inpatient services provided in an acute care hospital. (Provider Type (PT) 02) Encounters in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, valued on the outpatient hospital fee schedule are not eligible for reinsurance coverage. Encounters in which the day of admission and the day of transfer are the same, termed same day admit and transfer are eligible for reinsurance coverage.

- Skilled Nursing Facility (PT 22) services provided within thirty (30) days post discharge of an acute care stay, limited to ninety (90) days per contract year.

- Inpatient services provided in a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited psychiatric hospital (PT 71). Individuals, who are 21 through 64 years of age, have stay limitations of thirty (30) days per admission and sixty (60) days per ADHS contract year (July 1 through June 30).

- Care provided in a JCAHO accredited inpatient psychiatric facility such as a Residential Treatment Center (RTC) (PT 78, B1, B2, B3) or subacute facility (PT B5, B6). For individuals ages 21-64 (inclusive) in subacute facility with more than

sixteen (16) (PT B6) limitations of thirty (30) days per admission and sixty (60) days per ADHS contract year (July through June) apply.

- Care provided in a Medicare certified Institution for Mental Disease (IMD) for individuals over 65 years of age.

- Acute Behavioral Health Services up to 72 hours per episode for Title XIX and Title XXI members not yet RBHA enrolled.

There can only be one regular acute Reinsurance case per AHCCCS enrolled recipient per contract year, per Contractor. Reimbursement for Regular Acute Reinsurance benefits will be made once each month.

The following reports are available via the AHCCCS FTP Server for Contractor use and reference:

Reinsurance Remittance Advice	RI81L310
Reinsurance Case Summary	RI91L105
Reinsurance Case Initiation	RI91L100
Reinsurance Case Reconciliation	RI91L315

(Available in Comma Delimited format or Report Text Format)

III. Deductibles

The deductible level is based on the Contractor's statewide AHCCCS acute care enrollment (not including SOBRA Family Planning Extension members) as of October 1st each contract year. AHCCCS will adjust the Contractor's deductible level at the beginning of a contract year if the Contractor's enrollment changes to the next enrollment level**. Beginning October 1, 2009, and annually thereafter, each of the deductible levels below will increase $5,000 per year.** A Contractor at or above the 35,000 enrollment deductible level may elect a lower deductible level prior to the beginning of a new contract year.

Effective for Dates of Service 10/01/08-9/30/09

Statewide Plan Enrollment	***Annual Deductible****	
	Prospective Reinsurance	***Coinsurance***
0-34,999	**$20,000**	**75%**
35,000-49,999	**$35,000**	**75%**
50,000 and over	**$50,000**	**75%**

* applies to all members except SSDI-TMC, SOBRA Family Planning, State Only Transplants and PPC members

Deductible Carryover - When a member changes Health Plans within a contract year, Reinsurance eligible costs will not follow the member to the receiving Health Plan. A new reinsurance case will be opened with the receiving Health Plan if the member incurs eligible costs above the receiving Health Plan's deductible level.

Chapter Three
ALTCS Program Contractor & Ventilator Dependent Plans
Acute Reinsurance

I. Eligibility

Reinsurance is provided to partially reimburse the Program Contractor for covered services as described in contract and this manual, when the cost of care for a member exceeds a deductible amount within a contract year. All members who are enrolled with a Program Contractor on a capitated basis and meet the appropriate deductible amount are eligible for Reinsurance benefits. The deductible amounts and coinsurance percentages are detailed in contract. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible.

II. Determination of Benefits

Services that are covered under Reinsurance are specified in the AHCCCS Reinsurance System on the RI325 screen titled "RI Covered Services". Not all AHCCCS covered services are covered by Reinsurance. Long term care services or services usually covered under a facility's room and board charges are excluded from ALTCS Reinsurance benefits.

AHCCCS will use eligible adjudicated encounters, including but not limited to, outpatient and inpatient facility and professional and dental encounters to determine Reinsurance benefits for regular ALTCS reinsurance (case types LRO, LMO, LRW and LMW). PPC expenses are not covered under the reinsurance program for any members unless they qualify under catastrophic or transplant reinsurance.

III. Deductibles

The deductible level is based on the Program Contractor's statewide ALTCS enrollment as of October 1st of each contract year.

Effective for dates of service 10/01/08 forward:

Prospective Reinsurance

Statewide Plan Enrollment	*Deductible with Medicare Part A*	*Deductible Without Medicare Part A*	*Coinsurance*
0-1,999	**$10,000**	**$ 20,000**	**75%**
2,000+	**$20,000**	**$ 30,000**	**75%**

Chapter Four
Catastrophic Reinsurance

I. Eligibility

Catastrophic Reinsurance is provided to partially reimburse the Contractor for the cost of care for an enrolled member who meets Catastrophic Reinsurance criteria and requirements.

The Contractor is responsible for identifying the eligible recipient and notifying AHCCCS, Division of Health Care Management (DHCM), Medical Management Unit, in writing on a prescribed basis as outlined in this manual. Supporting medical documentation must accompany the request as outlined.

II. Determination of Benefits

The Contractor shall notify AHCCCS, DHCM, Medical Management Unit, of cases identified for catastrophic Reinsurance coverage for members diagnosed with Hemophilia, von Willebrand's and Gaucher's Disease or members receiving one or more of the covered Biotech drugs within thirty (30) days of

(a) initial diagnosis,
(b) enrollment with the Contractor,
(c) the beginning of each contract year.

Catastrophic Reinsurance, for members diagnosed with Hemophilia, von Willebrand's and Gaucher's disease will be paid for a maximum thirty (30) day retroactive period from the date of notification. The Director or designee shall make the determination of whether a case or type of case is catastrophic based on the following criteria:

(a) severity of medical condition, including prognosis
(b) the average cost or average length of hospitalization and medical care, or both, in Arizona, for the type of case under consideration.

HEMOPHILIA

Effective with dates of service 10/01/08 and forward, the following benefits and criterion apply:

For members diagnosed with hemophilia, all medically necessary covered services provided during the contract year shall be eligible for reimbursement. Adjudicated encounters for services provided to enrolled members with a diagnosis of hemophilia (ICD9 codes 286.0, 286.1, and 286.2) will be used to determine benefits.

The Contractor will be reimbursed at the lesser of the AHCCCS contracted rate or the Contractor paid amount for Hemophilia Blood Clotting Factor medications.

von WILLEBRAND'S DISEASE

Effective with dates of service 10/01/08 and forward, the following benefits and criterion apply:

For members diagnosed with von Willebrand disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement. Adjudicated encounters for services provided to enrolled members with a diagnosis of von Willebrand's Disease who are non-DDAVP responders and dependent on Plasma Factor VIII will be used to determine benefits.

GAUCHER'S DISEASE

For all members diagnosed with Gaucher's disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement. Encounters for services provided to enrolled members with a diagnosis of Gaucher's Disease classified as Type I and are dependent on enzyme replacement therapy will be used to determine benefits.

BIOTECH DRUGS

Catastrophic reinsurance is available to cover the cost of certain biotech drugs when medically necessary. These drugs, collectively referred to as Biotech Drugs, are the responsibility of the Contractor, unless the member is CRS enrolled, the medications are related to the management of a CRS covered condition, and CRS is providing coverage. Catastrophic reinsurance will cover the drug cost only. The drugs covered are Cerazyme, Ceprotin, Aldurazyme, Fabryzyme, Myozyme, and Elaprase. Kuvan and Orfadin are only covered for the CRS program. The Biotech Drugs covered under reinsurance will be reviewed by AHCCCS at the start of each contract year. AHCCCS reserves the right to require the use of a generic equivalent where applicable. AHCCCS will reimburse at the lesser of the Biotech Drug or its generic equivalent for reinsurance purposes. Adjudicated encounters for these covered services provided to enrolled members will be used to determine Reinsurance benefits.

STATE ONLY TERMINATIONS

On the day of pregnancy termination, all related outpatient medically necessary covered services will be eligible for Reinsurance reimbursement Adjudicated encounters for these covered services provided to enrolled members will be used to determine Reinsurance benefits. Reinsurance eligibility will be based on notification from the AHCCCS Clinical Quality Management Unit. See the AHCCCS Medical Policy Manual, Chapter 400, Policy 410 "Maternity Care Services".

PROGRAM CONTRACTORS & VENTILATOR DEPENDANT PLANS ONLY:

BEHAVIORAL HEALTH

Members considered by the DHCM, ALTCS Unit to be high-cost Behavioral Health (BEH) will also be covered under Catastrophic Reinsurance using separate guidelines. Placement into an institutional or HCBS setting for these members must be approved in advance by DHCM, ALTCS, Case Management Unit for the Program Contractor to qualify for Reinsurance reimbursement. BEH Reinsurance will cover the institutional or HCBS setting only.

Effective October 1, 2007, no new high-cost Behavioral Health Reinsurance cases will be approved; only ALTCS members already approved for this coverage as of September 30, 2007, will be reviewed for continued Behavioral Health Reinsurance coverage as described below. Members determined by the DHCM, ALTCS, Case Management Unit to meet high-cost Behavioral Health (BEH) criteria will continue to be covered by BEH Reinsurance for their institutional or HCBS setting only.

If the Contractor believes the member who has been approved for BEH Reinsurance continues to require a specialized treatment program and placement, a re-authorization request and supporting documentation must be submitted in writing to the ALTCS Case Management Unit of the Division of Health Care Management within ten business days prior to the expiration of the current approval. The submission date will be the date the request is received in writing by DHCM, ALTCS, Case Management Unit.

Authorizations are typically for six (6) months at a time, but may be for up to twelve (12) months, based upon the individual case. The requests should include the supporting documentation as described in Chapter 1600 of the AHCCCS Medical Policy Manual.

For Behavioral Health members, medically necessary covered services provided during the contract year shall be eligible for reimbursement. Adjudicated encounters for covered services provided to enrolled members with significant behavioral management problems will be used to determine reimbursement. Reinsurance coverage will be based on documentation substantiating that the member has been placed in the least restrictive treatment setting to safely manage the member's needs.

Failure to comply with AHCCCS requirements may result in the denial of Reinsurance reimbursement.

III. Deductibles

Case Type	Deductible	Coinsurance
Hemophilia	$0	85%
von Willebrand's	$0	85%
Gaucher's	$0	85%
Biotech Drugs	$0	85%
State Only Terminations	$0	100%
Behavioral Health	$0	75%

Chapter Five
Other Reinsurance

For all reinsurance case types **other than transplants**, Contractors will be reimbursed 100% for all medically necessary covered expenses provided in a contract year, after the reinsurance case total value meets or exceeds $650,000 (total health plan paid amount including the deductible). Once this level is met, the Contractor must notify, via email, the AHCCCS Reinsurance Supervisor in order to create the CRA case and receive enhanced Reinsurance benefits. Once the CRA case has been created, it is the Contractors' responsibility, if necessary, to split the encounters to associate to the newly created CRA case. Failure to notify AHCCCS or failure to split and adjudicate encounters appropriately within 15 months from the end date or service will disqualify the related encounters for 100% reimbursement consideration.

Chapter Six
Transplants

I. ELIGILIBITY

Transplant Reinsurance is provided to partially reimburse Contractors for the cost of care for an enrolled member who meets Transplant Reinsurance criteria and requirements as specified in the AHCCCS Medical Policy Manual, Chapter 300, Policy 310.

This program covers members who are eligible to receive covered major organ and tissue transplantation, as described in the State Plan, including bone marrow, heart, heart/lung, single and double lung, liver, kidney, simultaneous pancreas/kidney and pancreas after kidney and other organ transplantation. Bone grafts and cornea transplantation services are not eligible for Transplant Reinsurance coverage but are eligible under the regular Reinsurance program. An AHCCCS covered transplant related inpatient hospital stay for days 61-100 post transplant (PTI case type) will be eligible for Regular Reinsurance coverage however, the deductible is waived for these services only. Individuals who qualify for transplant services, but who are later determined ineligible, due to excess income may qualify for extended eligibility (refer to State Only Transplants Option 1 and Option 2 below). When a member is referred to a transplant facility for an AHCCCS covered transplant, the Contractor must notify the DHCM, Medical Management Unit within 30 days in order to receive transplant Reinsurance benefits.

The Contractor's Medical Director is responsible for submitting to the AHCCCS Medical Director, a written request for approval of a covered organ or tissue transplantation for Reinsurance. The request must be accompanied by a current history and physical and records of the evaluation leading to recommendation for transplantation. The AHCCCS Medical Director or designee will review the submitted documentation, consult with the appropriate transplant committee and inform the Contractor's Medical Director in writing of the decision.

II. COVERED TRANSPLANTS

Bone Marrow Transplantation, Allogenic and Autologous

Heart Transplantation

Heart – Lung Transplantation

Intestinal Transplantation (Small Bowel or Liver/Small Bowel) for Pediatric Members Only

Kidney Transplantation (cadaveric and live donor)

Liver Transplantation

Single Lung Transplantation

Double Lung Transplantation

Pancreas after Kidney Transplantation

Simultaneous Pancreas/Kidney Transplantation

III. DOCUMENTATION

Contractors must submit the following documentation to the DHCM Reinsurance Unit for each stage of the Solid Organ and Tissue (Bone Marrow) Transplantation:

1. An invoice cover sheet, available on the AHCCCS website furnished below, and a copy of the invoice from the contracted facility. Each stage must be identified in this manner and include the documentation listed below. For a non-contracted facility a letterhead cover sheet from the facility with a breakdown of dates of service and total charges will be accepted.
   http://www.azahcccs.gov/PlansProviders/reinsurance/Reinsurance.asp
2. Hard copy of hospital UB92 or a mock UB92 with an itemized statement of the hospitalization for all tests/procedures (coded) for performed services.
3. All appropriate HCFA 1500's submitted by the dates of service for the component. Totaled for reference.
4. The Contractor's paid amount must be clearly identified for each component.
5. Proof of payment to the facility.
6. Do not send medical documentation.
7. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounters must agree with related claims and/or invoices. Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage.

Contractors shall provide the information stated above to:

AHCCCS Reinsurance Unit

701 East Jefferson St

Mail Drop 6600

Phoenix, Arizona

85034

IV. STATE ONLY TRANSPLANTS

Option 1 and Option 2 Transplant Services: Reinsurance coverage for State Only Option 1 and Option 2 members for transplants received at an AHCCCS contracted facility is paid at the lesser of 100% of the AHCCCS contract amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. When a member is referred to a transplant facility for an AHCCCS

covered organ transplant, the Contractor shall notify AHCCCS, Division of Health Care Management, Medical Management Unit as specified in the *AMPM Chapter 300, Policy 310 Attachments A and B, Extended Eligibility Process/Procedure for Covered Solid Organ And Tissue Transplants*.

Option 1 Non-transplant Reinsurance: All medically necessary covered services provided to Option 1 members, unrelated to the transplant, shall be eligible for reimbursement, (ST1 case type) with no deductible, at 100% of the Contractor's paid amount based on adjudicated encounters.

V. OUT OF STATE TRANSPLANT

A transplant performed out of state at a non-contracted facility will be reimbursed at 85% of the lesser of the in state AHCCCS transplant contracted rate if available, or the health plan paid amount.

VI. OUTLIER PARAMETERS

A transplant case may qualify for outlier coverage when a specified contractual deductible is met or exceeded. When submitting a request for outlier consideration the outlier worksheet must accompany the request. The worksheet is available on the AHCCCS web site furnished below.

http://www.ahcccs.state.az.us/PlansProviders/reinsurance/TransplantOutlierTemplate_contractors1.xls

The following information must be sent with the outlier request:

1. All completed stage invoices with supporting documentation.
2. Proof of payment to the facility.
3. Detail of all non-covered charges by stage.
4. Support for amounts submitted on the outlier template (support must balance to outlier template or it will be returned).
5. The Contractor is required to submit all supporting encounters for transplant services. Reinsurance payments will be linked to transplant encounter submissions.

VII. TIMELY FILING AND ENCOUNTER SUBMISSION

Transplant stage invoicing must be submitted no later than fifteen (15) months from end date of service for the transplant stage. Outlier invoicing must be submitted no later than fifteen (15) months from the end date of the last completed stage. The Contractor is required to submit all supporting encounters for transplant services. Reinsurance payments will be linked to transplant encounter submissions. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounter submissions must agree with supporting transplant stage claims and/or invoices. **Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage**.

Chapter Seven
Coordination of Benefits and Third Party Payments

Pursuant to federal and state law, AHCCCS is the payer of last resort except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2903, and A.A.C. R9-22-1001 et seq. so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party.

The two methods used in the coordination of benefits are cost avoidance and post payment recovery. The Contractor shall use these methods as described in A.A.C. R9-22-1001 et seq. and federal and state law.

Contractors are required to notify AHCCCS or its authorized representative, within ten (10) business days of the identification of a 1st or 3rd party liability case with known Reinsurance. Failure to comply with the notification requirements may result in those sanctions specified in contract. Should AHCCCS or its authorized representative identify third party recovery payments received by the Contractors that do not comply with the notification requirements in this section the following actions shall occur:

A. For open cases, AHCCCS shall reimburse itself 100% percent of any duplicate payments by adjusting the Reinsurance case. An administrative fee of 15 percent of the duplicate payments shall be added to the adjustment.

B. For closed cases, AHCCCS or its authorized representative shall bill the contractor directly for 100% percent of the duplicate payments. An administrative fee equal to the current TPL Contractor's contingency fee schedule shall be added to the billing.

All Medicare and Third Party payers' should be billed and the encounter adjudicated through the Contractor's system prior to submission to AHCCCS. In addition, the Medicare Allowed, Medicare Paid, Third Party Payments and Value Code fields, as applicable, must be completed when the encounter is submitted for Reinsurance consideration.

Chapter Eight
Time Limits for Filing Reinsurance Claims

A claim for reinsurance may be filed for any encounter of an AHCCCS reinsurance covered service. In order to qualify for reinsurance consideration, the reinsurance claim must be filed and must reach clean claim status within the submission timeframes described below. An inpatient reinsurance claim consists of a valid encounter containing the information specified in this manual and contract. Reinsurance claims for regular reinsurance cases (case types RAC, LMO, LMW, LRO and LRW) are created automatically by PMMIS once the encounter reaches an adjudicated status through the Encounter System. For all other types of reinsurance claims, however, the Contractor must file a written request for reinsurance consideration with the AHCCCS DHCM, Medical Management Unit. Except for retro-eligibility situations, claims for reinsurance must be submitted to AHCCCS and must attain a clean status no later than fifteen (15) months from the end date of service. For reinsurance claims regarding retro eligibility encounters, the claim for reinsurance must be submitted to the AHCCCS Administration and must attain a clean claim status no later than fifteen (15) months from the date of *eligibility posting.*

If a claim that gives rise to a reinsurance claim is the subject of a grievance or appeal proceeding or other legal action, the Contractor has 90 days from the date of the final decision in that proceeding/action to file the reinsurance claim AND for the reinsurance claim to reach clean claim status.

Note that a "clean" claim/encounter is one that has passed all of the Encounter and Reinsurance edits and that can be processed without obtaining additional information from the provider of service, the contractor, or from a third party. This does not include claims under investigation for fraud or abuse or claims under review for medical necessity. With respect to hospital/long term care encounters, “date of service” means the date of discharge.

Chapter Nine
Reimbursement

AHCCCS will reimburse a Contractor for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages. Covered amounts in excess of the deductible level shall be reimbursed based upon costs paid by the Contractor, net of interest, penalties, discounts and coinsurance, unless the costs are paid under a subcapitated arrangement. In subcapitated arrangements AHCCCS shall base reimbursement of Reinsurance encounters on the lower of the AHCCCS allowed amount or the reported Health Plan paid amount, net of interest, penalties, discounts and coinsurance.

Subcapitated and CN1 Codes recognized by Reinsurance:

CN1 Indicator Crosswalk to Sub Cap Codes

CN1	DEFINITION	SUB CAP	DESCRIPTION
Blank		00	No subcapitated payment arrangement. Used to report services paid on a fee-for-service basis. When subscriber exception code is 25, subcap code is 05.
01	Diagnosis Related Group (DRG)	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
02	Per Diem	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
03	Variable Per Diem	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
04	Flat	00	Full Subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05
05	Capitated	01	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05
06	Percent	00	Partial subcapitation arrangement. Used to report services provided by a subcapitated provider that are excluded from the subcapitated payment arrangement. When subscriber exception code is 25, subcap code is 05
09	Other	08	Negotiated settlement. Used to report services that are included in a negotiated settlement, for example, claims paid as part of a grievance settlement, when subscriber exception code is not 25.
09	Other	04	Contracted transplant service (covered under AHCCCS catastrophic reinsurance) Used to report covered transplant services paid via catastrophic reinsurance, when subscriber exception code is 25.
	Identified by Filename	06	Denied claim used to report valid AHCCCS services that are denied. For example, if a claim was denied for untimely submission.

When a void encounter is submitted for a previously paid associated Reinsurance encounter, the reinsurance payment related to the voided encounter will be recouped. When a void-replace encounter is submitted and the replaced health plan paid amount is less than the original health plan paid amount, the difference will be recouped. When a void-replace encounter is submitted and the replaced health plan paid amount is greater than the original health plan paid amount, any additional reinsurance payment due will only be paid if the void-replace encounter was adjudicated and reached clean claim status within 15 months from end date of service, or date of eligibility posting, whichever is later. If the void-replace was not submitted timely, reinsurance reimbursement will be calculated and paid up to the original health plan paid amount, no additional reinsurance dollars will be paid.

If a Contractor submits a void-new day encounter when the situation warrants a void-replace encounter according to encounter submission protocol, the reinsurance system will recoup all reinsurance payments made related to the voided encounter, and the new day encounter will be subject to timely filing limits of 15 months from end date of service, regardless of when the original encounter was adjudicated.

Chapter Ten
Appeal/Claim Dispute Process

Contractors must follow AHCCCS' reinsurance submission processes described in contract and this manual in order for encounters to be reviewed for potential reinsurance payment. If a Contractor has exhausted the reinsurance refiling/reconsideration processes and still disagrees with an action taken regarding a reinsurance claim, the Contractor may file a claim dispute concerning the denial or adjudication of an encounter. In order for a service and the corresponding encounters to qualify for reinsurance coverage, the service must independently meet criteria for coverage of reinsurance based on consideration of **all** relevant information and documentation. A Hearing Decision which determines that a Contractor must reimburse a particular medical service does not, in and of itself, establish that the service qualifies for reinsurance coverage, under either catastrophic, behavioral health or inpatient reinsurance. Hearing Decisions are based on evidence from the official hearing record which may be limited depending upon the arguments presented by the parties. Reinsurance coverage determinations are based on evaluation of **all** pertinent information and data, whether or not the information was presented at a hearing. For all transplant case types, it is critical that Contractors perform timely and complete evaluations to determine whether a particular transplant is medically necessary, is considered the standard of care, and is not considered experimental. An AHCCCS Transplant Consultant is available to assist Contractors in those determinations. If it is determined by AHCCCS that a transplant does not meet criteria for catastrophic reinsurance coverage, it will **not** be covered under inpatient reinsurance coverage (previously referred to as "regular" reinsurance coverage) Also, Contractors are prohibited from recouping monies paid to providers for services authorized by the Contractor but which have been subsequently denied reinsurance coverage by AHCCCS.

All claim disputes must be submitted to AHCCCS within the filing deadlines. To be considered timely, claim disputes challenging a denial of reinsurance claim or a reinsurance adjudication must be filed no later than 90 days from the date of adverse action of the reinsurance claim

All claim disputes must be in writing and must explain both the factual and the legal reasons supporting the Contractor's position that AHCCCS' action was incorrect. The address for filing a claim dispute is:

AHCCCS Office of Administrative Legal Services
Mail Drop 6200
P. O. Box 25520
Phoenix, AZ. 85002